DOCUMENT RESUME

ED 281 102 CG 019 836

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TITLE Primary Mental Health Care in the Americas.
PUB DATE Sep 86
NOTE 18p.; Paper presented at the Annual Meeting of the American Public Health Association (114th, Las Vegas, NV, September 28-October 2, 1986).
PUB TYPE Reports - General (140) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Community Health Services; *Cross Cultural Studies; Developed Nations; Developing Nations; Foreign Countries; Human Resources; Mental Health Clinics; *Mental Health Programs; *Primary Health Care
IDENTIFIERS *Latin America; *United States

ABSTRACT

This paper outlines selected differences between the United States and Latin America health care systems as they relate to primary mental health care. It notes that historically both the United States and Latin America have relied on custodial psychiatric hospitals. The alternative of community care for psychiatric patients is described as it is being implemented in the United States and in developing countries. Striking differences between mental heatlh care in developed and in developing countries are examined, including differences in per capita health care expenditures, patient/psychiatrist ratios, and the distribution of specialized human resources. Population projections for developed and developing nations are given which suggest that by the year 2,000, 80% of the world's population will live in developing countries with insufficient general and mental health services. A section on the current situation examines differences in how the United States and Latin America have attempted to develop new systems of community care. The development of community mental health centers separate from the general health sector in the United States and the development of a system of ambulatory mental health care integrated with the general health sector at the primary care level in Latin America are discussed. The report suggests that the United States study the strategies, strengths, and weaknesses of Latin America's comprehensive model to address its own health care problems more effectively. (NB)

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ED281102

Primary Mental Health Care in the Americas

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Paper presented at the 114th Annual Meeting of the American Public Health Association International Health Section, Las Vegas, September 28-October 2, 1986.

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TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

The historical, socio-economic and political differences between developed and developing countries are well known, and give special characteristics to the psychiatric problems seen at the primary level of care, from both a clinical and programmatic viewpoint. This paper outlines selected differences between the United States and Latin American health care systems as they relate to primary mental health care.

I. Historical Aspects and Social Economic Situation

The so-called "modern" psychiatry depends for its adequate functioning on the existence of urbanized and industrialized societies, adequate resources, concentration of the population in cities, efficacious transportation and communication systems, well-trained personnel and public acceptance of the psychiatrist (17). In Latin America, conventional psychiatry is a product of its colonial European heritage and of the technological transfer from the United States (9,26). As a discipline, to a large extent it has not extended its services to the rural communities or to the urban marginal populations, has absorbed an unjustifiable amount of resources to provide custodial services, has been used as an instrument for social control, has suppressed traditional forms of health care, and has failed to obtained the necessary credibility with the general public.

In the United States a similar situation has happened. The custodial psychiatric hospital was developed during the last century as alternative institutions for the adequate care of the chronically mentally ill. These functions have deteriorated over time, however, and have evolved into exerting social control to

maintain the order in the cities, without delivering adequate mental health services. The psychiatric illnesses they were supposed to treat were in reality made worse by the development of secondary symptoms that had their origins in the alienated condition of the patients and the lack of medical care, what has been called by Gruenberg the "chronic social breakdown syndrome" (13).

In the second half of this century, however, a radical change took place in the delivery of mental health care both in the United States and in Latin America. In the U.S. in 1955 there were 1.7 million episodes of mental health care of which 75% were inpatient admissions. In 1975 there were 6.5 million episodes of mental health care of which 73% were outpatient contacts. Of the 600,000 resident patients in psychiatric hospitals in 1950 there were only 150,000 in 1981. The transfer of mental health care to the community was made possible partially because in this period community mental health centers (CMHC) were created and in 1982, 744 were already functional (27).

The alternative of maintaining the chronic psychiatric patient in the community instead of in custodial hospital care is also being implemented in the developing countries and it is necessary to highlight some contextual issues.

Firstly, the social economic indicators related to health in the developed and developing countries show fairly clearly the extend of the differences. For example, even though health care

expenditure "per capita" is $144 in developed countries, it is only $1.7 in the least developed countries, corresponding to 3.9% and 1% of their gross national products, respectively (35). Secondly, the distribution of specialized human resources is radically different. If the prevalence of serious mental illnesses is 1% of the general population, the proportion of patient to psychiatrist is 1:8 in the United States, 1:20,000 in Nigeria and 1:50,000 in Ethiopia. Expressed in other ways, for each million population, there are 120 psychiatrists in the United States and one in Asia or Africa (25). Lastly, the population projections for the two halves of the world indicate these differences will be made worse, as by the year 2,000 the developing countries will concentrate 80% of the world's population, with clear consequences for the delivery of health services in general and mental health services in particular. Due to the differential increase in the age groups at higher risks for the development of specific mental disorders, their crude prevalence rates will increase both in developed as in developing countries but the increase will be much greater in the latter. For example, if only the population change is considered, its estimated that the crude prevalence rate for schizophrenia will have an increase until the age 2,000 of 16.9% for the developed countries, but it will increase by 95% in the Third World (21). This underlines the imbalance between the demand for mental health services and the actual possibilities for health care by the specialized sector, that will be made

increasingly worse in the next decade.

II. Current Situation

UNITED STATES

The United States and the developing countries have understood the inadequacy of the traditional hospital system, but the efforts to develop the new system of community care have followed different routes. In the United States, the transfer of the psychiatric patient from the custodial hospital into the community has required the development of CMHC separate from the general health sector (4). This situation has led to a significant distortion in clinical practice. CMHC were developed in isolation from the general health sector, precisely in a period when the movement within psychiatry was of a re-approximation and reaffiliation with medicine. Partially as a result of this development, CMHC have become unattractive for psychiatrists, who have essentially abandoned them. From 1970 to 1979, the average proportion of psychiatrists in the CMHC treatment teams decreased from 36% to 5.8% (3). CMHC, that should care for the deinstitutionalized patients, concentrated their attention initially in new types of patients, that is, patients with the neurotic and personality disorders, or in crisis, giving to the psychotherapeutic interventions and to the non-medical professionals an adequate and relevant role.

On the other hand, the general health services at the outpatient care had a special thrust in the year '60s when 1,000 primary care clinics were established in areas that had limited

health care services (7), but an adequate coordination between the primary care and mental health sectors was never established (31).

With accumulation of experience, the artificiality inherent in this dichotomization between mental and general health care has become self-evident, indicating that integrated delivery models should be developed to care for the concurrent psychiatric and physical morbidity of the patients attending these services.

It is known today, for example, that the most frequent causes of death in the United States are the coronary and cerebrovascular diseases, cancer and accidents. In these cases, the maladaptive human behaviors, such as stress, sedentarism, alcoholism and drug abuse, smoking and obesity have a prominent role, emphasizing the close relationship between the psychosocial factors and physical morbidity (16).

In the general health services, it has been estimated a 20% psychiatric morbidity among patients, that may occupy more than 70% of the general practitioner's time, being closely related to the excessive utilization of the general health services (5). It is also known that the general health sector manages 2/3 of the mental health problems in the United States (30), estimated in 15% of the general population (29).

General health services benefit from a mental health component. When there is an integration of mental health services to the general health services, it is noted an increase in the detection of psychiatric cases, an increase in appropriate

referrals to the specialized sector, a better follow-up of patients, and a decrease in the overall cost of services rendered (19).

Besides the realization that mental disorders and psycho-social problems are frequent and important in general health services, it is also known that physical problems are frequent in chronic psychiatric patients who are cared for in the CMHC (2). With the deinstitutionalization process, chronic patients formerly located in custodial hospitals now receive these services in the community (1), requiring a wide network of community support systems (6). In addition to housing, financial support, psycho-social rehabilitation and psychiatric care, these patients also require medical care. In as much as psychiatric visits are usually scheduled at least monthly and visits to medical services tend to be much less frequent, it becomes a "de facto" responsibility of the psychiatric services to detect and refer patients to general health services for evaluation and treatment of the identified physical problems. Nonetheless, CMHC, that have very limited participation of the psychiatrist, are not prepared to handle this new psychiatric and physical co-morbidity. As a consequences, patients may not have their problems diagnosed (15), may not receive adequate treatment (14), the medical and psychiatric treatments may run in parallel, perhaps in opposition to each other, with minimal or inexistent coordination between general health and mental health clinics (24).

LATIN AMERICA

In the developing world, scarce human resources did not permit that the transition of custodial hospital services to the community included the phase of the CMHC center functioning in parallel to the general and public health systems (22). In this manner, even though facing a variety of difficulties, the Latin American countries have developed a system of ambulatory mental health care integrated with the general health sector at the primary level of care.

As Giel and Harding state (12), mental disorders in the developing world are a public health problem that is clearly excessive to be managed by psychiatry, so that the integration of mental health services with general health services is all but unavoidable. This reality lead Lynn to state that "the future of mental health services in the Third World depends on a large extent on the success of the integration of mental health services to primary care services" (25).

In the Third World, attempts have been made to develop the training and education of new professionals who, at the primary level of care, are capable of including the various mental health actions into their health work, such as the promotion of 'mental health, the early detection of problems, the adequate management and referral of patients, and the follow-up of chronically mentally ill, in close collaboration with the community and with the continuing support of the specialized sector through supervision, consultation and training (8).

The WHO collaborative study on the extension of mental health services in developing countries (11,18) has led to innovative approaches in the centers that participated in the project. The training of the primary care worker to carry out basic and well-defined actions in mental health was successfully accomplished. Among the strategies developed for the training, manuals were elaborated in Colombia (10), Brazil (23) and India (32), that were subsequently adopted by the general health services. The need to establish priorities, to standardize the therapeutic approach through flowcharts, and to provide continuing specialized support have been clearly accepted.

III. Conclusion

Ten years ago, the WHO expert committee on mental health (34) recommended that mental health services in developing countries be integrated into the general health services at all levels of care, particularly at the primary level of care. The specialized sector would have functions of facilitation, training, supervision and support, while the health care worker would carry out basic and well-defined mental health actions, becoming the "cornerstone of community psychiatry" (33).

The scarcity of resources and the socioeconomic limitations of Latin America have promoted the integration of ambulatory mental health services into the general health services, with the delivery of comprehensive health care at the primary care level (28). This model has been only partially implemented in Latin America due to the socio-economic problems that exist, but it has

oriented the development of health policies and it is known that through continuing efforts it will widen its coverage. The health care model currently existing in the United States, that has evolved without similar scarcity of resources, shows a lack of attention to these integrative principles that have been operationalized at the programmatic level in various countries of the world. The unintend consequences is the lack of integration between the general health sector and the mental health sector, significantly diminishing the quality of care of being provided, in spite of adequate resources. The result is that today there is a systemic incapacity for the management of physical problems in the CMHC, and of mental health problems in the general health centers. Problems purely mental or physical are well known abstractions, and its surprising that the health care model in the United States has implicitly utilized them to orient its development.

The Latin American situation is a clear example that, if underdevelopment brings a disquieting multiplicity of problems and difficulties, at times it also creates the opportunity for the creation of original alternatives, appropriate to the needs of the patient. The Latin American model is presenting a comprehensive health care system that addresses the biopsychosocial needs of the patients, whose strategies, weaknesses and strengths the United States should study carefully to approach its own health care problems more effectively.

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EPISODES OF MENTAL HEALTH CARE

UNITED STATES

	1955	1975
TOTAL (MILLIONS)	1.7	6.9
ADMISSIONS	75%	27%
OUTPATIENT VISITS	25%	73%

HEALTH AND SELECTED SOCIO-ECONOMIC INDICATIONS

	LEAST DEVELOPED COUNTRIES	OTHER DEVELOPING COUNTRIES	DEVELOPED COUNTRIES
NUMBER	29	90	37
POPULATION (MILLIONS)	283	3001	1131
INFANT MORTALITY RATE	160	94	19
LIFE-EXPECTANCY AT BIRTH	45	60	72
PERCENTAGE WITH BIRTH WEIGHT 2,500 GM +	70%	83%	93%
ADEQUATE WATER SUPPLY	31%	41%	100%
ADULT LITERACY RATE	28%	55%	98%
GNP, PER CAPITA	$170	$520	$6,230
PUBLIC HEALTH EXPENDITURES, PER CAPITA	$1.7	$6.5	$244
PUBLIC HEALTH EXPENDITURES, AS % OF THE GNP	1.0%	1.2%	3.9%

PERCENT DIFFERENCE FOR
THE POPULATION IN DEVELOPING AND
DEVELOPED COUNTRIES BY AGE
1975-2000

AGE	PERCENT DIFFERENCE 1975 - 2000		
	TOTAL	DEVELOPED COUNTRIES	DEVELOPING COUNTRIES
TOTAL	57.6	20.2	72.6
< 15	41.8	8.6	50.0
15-24	56.5	4.2	75.0
25-34	72.2	16.9	95.0
35-44	74.5	33.2	95.0
45-64	64.5	30.5	86.7
65-74	68.9	33.2	104.2
75-79	84.3	53.0	121.2
80+	91.7	64.7	138.0